1) Suggested MCO op-ed
2) Suggested MH system op-ed
3) Suggested cure for not enough $ in state budget

1st Quarter 2017 MCO report

568,454 in Medicaid
- 170,254 30% United Health Care
- 185,833 33% Amerigroup
- 212,367 37% Amerihealth

606,154 All MCO Enrollment by program
- 37,700 – 6% - Hawk-I
- 141,510 - 23% - Iowa Wellness Plan
- 426,944 – 71% - Medicaid

Long term services & supports (LTSS)
- 38% - 14,015 – facility based
- 62% - 22,810 – community based

Pg. 4-33 – enrollment #'s and population reporting

Pg. 34-39 – **Consumer protections and supports standards** are:

Pg. 34-35 - 100% of grievances resolved within 30 calendar days of receipt
# of grievances filed (436), Top 5 reasons for grievances

Pg. 35-36 - 100% of appeals resolved within 45 days of receipt
# of appeals (686), Top 5 reasons for appeals for all 3 MCO's – pharmacy was #1
Hearing Summary

Pg. 37 - HCBS critical incidents – *need better breakdown of types of incidents?*
Special needs, behavioral health and elderly are categories of critical incidents

	Amerigroup	Amerihealth	United Health
Total HCBS	*3034*	*17,187*	*2589*
# of critical incidents	*812*	*3271*	*353*
% of critical incidents	*27%*	*19%*	*13.6%*

100% of service plans completed timely
Results = 75 to 88% being completed timely
100% of Level of Care (LOC) Reassessments completed timely
Results = 2/3 completed timely

Pg. 40 - Member Helpline – all 3 MCO's meet the contractual requirement – 80% of helpline calls are answered timely and not abandoned - range from 86% to 100%
Top 5 reasons for contacting the Helpline

Pg. 41 - Provider Helpline – 80% of helpline calls are answered timely and not abandoned - range from 79% to 92%
Top 5 reasons for contacting the Helpline

Pg. 42 – Pharmacy Helpline - 80% of helpline calls are answered timely and not abandoned range from 78 – 94%

Pg. 43 - 90% of Clean Medical Claims Must be Paid or Denied Within 14 Days
range from 94.3 to 99.8%

Pg. 43 - 99.5% of Clean Medical Claims Must be Paid or Denied Within 21 Days
range from 97.2 to 100%

Pg. 44 – Amerigroup Medical Claims status – 70% paid, 10% denied, 20% suspended
Amerihealth Medical Claims status – 72% paid, 10% denied, 18% suspended
United Healthcare Claims status - 65% paid, 15% denied, 20% suspended
Top 10 reasons for medical claim denial

Pg. 48 - 90% of Clean Pharmacy Claims Must be Paid or Denied Within 14 Days
Range from 99.4% to 100%

99.5% of Clean Pharmacy Claims Must be Paid or Denied Within 21 Days
Range from 99.6% to 100%

Amerigroup Pharmacy Claims Status – 73% paid, 27% denied
Amerihealth Pharmacy Claims Status – 76% paid, 24% denied
United Health Care Pharmacy Claims Status – 73% paid, 27% denied
Top 10 Reasons for Pharmacy Claims Status

Pg. 51 - Utilization of Health Care Services Provided
Total Dollars each MCO paid in Emergency Dept. claims reimbursed,
Inpatient Medical claims reimbursed,
Inpatient Behavioral Health claims reimbursed,
Outpatient claims reimbursed

Pg. 52 – Utilization of Value Added Services Reported – Count of Members

Pg. 53-61 - **Network adequacy and historical utilization**

The network adequacy tool is based on Medicaid members' historical utilization of services. Historical utilization is a measure of the percentage of assigned members whose current providers are part of the managed care network for a particular service or provider type based on claims history.

There are two major methods used to determine adequacy of network in the contract between the department and the MCOs: • Member and provider ratios by provider type and by region • Geographic access by time and distance

Percentage of Members with Coverage in Time and Distance Standards

100% of Counties Have ≥ 2 HCBS Providers Per County Per 1915c Program
Amerigroup 21% Amerihealth 42% United Health 90%

100% of Regular Prior Authorizations (PAs) Must be Completed Within 7 Calendar Days of Request – Range from 95-100%

100% of PAs for Expedited Services Must be Authorized Within 3 Business Days of Request
Range – 91% to 100%

Amerigroup Medical PAs Status – 93% approved, 7% denied
AmeriHealth Medical PAs Status – 93% approved, 7% denied
United Health Medical Pas Status – 93% approved, 7% denied

100% of Regular PAs Must be Completed Within 24 Hours of Request - all MCO's at 100%

Amerigroup Pharmacy PAs Submitted Status – 73% approved, 27% denied
Amerihealth Pharmacy PAs Submitted Status – 64% approved, 36% denied
United Health Pharmacy PAs Submitted Status – 80% approved, 20% denied

Encounter Data are records of medically-related services rendered by a provider to a member. The department continues the process of validating all encounter data to ensure adequate development of capitation rates and overall program and data integrity –
Encounter data has to be entered by the 20th of the month

% of Members Covered by a Value Based Purchasing Agreement

Pg. 62-65 - MCO Financials

MCOs are required to meet a minimum medical loss ratio of 88% per the contract between the department and the managed care organizations.

- Medical loss ratio (MLR) reflects the percentage of capitation payments used to pay medical expenses.
- Administrative loss ratio (ALR) reflects the percentage of capitation payments used to pay administrative expenses.
- Underwriting ratio reflects profit or loss.

A minimum medical loss ratio protects the state, providers, and members from inappropriate denial of care to reduce medical expenditures. A minimum medical loss ratio also protects the state if capitation rates are significantly above the actual managed care experience, in which case the state will recoup the difference

Q1 FY 17	Amerigroup	Amerihealth	United Health
MLR	109.92%	114.05%	111.88%
ALR	7.85%	6.65%	13.36%
Underwriting	-17.78%	-20.7%	-25.24%

Program cost savings	Projected State Spending without Managed Care	$372,185,691
	Actual State Spending with Managed Care	$342,520,628
	Savings	$ 29,665,063

Provider type reimbursement during quarter by MCO's
Total Capitation Payments Made to the Managed Care Organizations
Managed Care Organization Reported Reserves
Third Party Liability Recovery for Q1 SFY17

Pg. 66 – Program Integrity

Fraud, Waste and Abuse – investigations, overpayments, quarterly amount of recovery, year-to-date amount of recovery, cases referred to Medicaid fraud unit, and member concerns referred to IME

Pg. 67 – Health Outcomes

Hospital Admissions
Use of Emergency Dept.
Out of state Placement

HEDIS measures - http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2017
CAHPS measures - https://www.ahrq.gov/cahps/index.html
3M Treo Value Index Score tool developed for the State Innovation Model (SIM) grant
https://dhs.iowa.gov/sites/default/files/V2V_2016June_FINAL.pdf

Appendix – Pg. 71

HCBS Waiting lists – Oct. 2016

Q1 SFY17 –Compliance Remedies

Glossary